§413.215 Basis of payment.

(a) Except as otherwise provided under §413.235 or §413.174(f) of this part, effective January 1, 2011, ESRD facilities receive a predetermined per treatment payment amount described in §413.230 of this part, for renal dialysis services, specified under section 1881(b)(14) of the Act and as defined in §413.217 of this part, furnished to Medicare Part B fee-for-service beneficiaries.

(b) In addition to the per-treatment payment amount, as described in §413.215(a) of this part, the ESRD facility may receive payment for bad debts of Medicare beneficiaries as specified in §413.178 of this part.

[75 FR 49200, Aug. 12, 2010]

§413.217 Items and services included in the ESRD prospective payment system.

The following items and services are included in the ESRD prospective payment system effective January 1, 2011:

(a) Renal dialysis services as defined in §413.171; and

(b) Home dialysis services, support, and equipment as identified in §410.52 of this chapter.

[75 FR 49200, Aug. 12, 2010]

§413.220 Methodology for calculating the per-treatment base rate under the ESRD prospective payment system effective January 1, 2011.

(a) *Data sources.* The methodology for determining the per treatment base rate under the ESRD prospective payment system utilized:

(1) Medicare data available to estimate the average cost and payments for renal dialysis services.

(2) ESRD facility cost report data capturing the average cost per treatment.

(3) The lowest per patient utilization calendar year as identified from Medicare claims is calendar year 2007.

(4) Wage index values used to adjust for geographic wage levels described in §413.231 of this part.

(5) An adjustment factor to account for the most recent estimate of increases in the prices of an appropriate market basket of goods and services provided by ESRD facilities.

(b) *Determining the per treatment base rate for calendar year 2011.* Except as noted in §413.174(f), the ESRD prospective payment system combines payments for the composite rate items and services as defined in §413.171 of this part and the items and services that, prior to January 1, 2011, were separately billable items and services, as defined in §413.171 of this part, into a single per treatment base rate developed from 2007 claims data. The steps to calculating the per-treatment base rate for 2011 are as follows:

(1) *Per patient utilization in CY 2007, 2008, or 2009.* CMS removes the effects of enrollment and price growth from total expenditures for 2007, 2008 or 2009 to determine the year with the lowest per patient utilization.

(2) *Update of per treatment base rate to 2011.* CMS updates the per-treatment base rate under the ESRD prospective payment system in order to reflect estimated per treatment costs in 2011.

(3) *Standardization.* CMS applies a reduction factor to the per treatment base rate to reflect estimated increases resulting from the facility-level and patient-level adjustments applicable to the case as described in §413.231 through §413.235 of this part.

(4) *Outlier percentage.* CMS reduces the per treatment base rate by 1 percent to account for the proportion of the estimated total payments under the ESRD prospective payment system that are outlier payments as described in §413.237 of this part.

(5) *Budget neutrality.* CMS adjusts the per treatment base rate so that the aggregate payments in 2011 are estimated to be 98 percent of the amount that would have been made under title XVIII of the Social Security Act if the ESRD prospective payment system described in section 1881(b)(14) of the Act were not implemented.

(6) *First 4 Years of the ESRD prospective payment system.* During the first 4 years of ESRD prospective payment system (January 1, 2011 to December 31, 2013), CMS adjusts the per-treatment base rate in accordance with §413.239(d).

[75 FR 49200, Aug. 12, 2010]